

BAH-00465849 IP5-00176074
Master MOHAMMED AARIB JIBRAAN
17-11-2019 6 Y 7 M 21 D (M)
Pa Dr. ALISHA BABBAR



Sheshan
09/07/26

Rainbow
Children's
Hospital
It takes a lot to treat the little.

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Fe not done

SURGERY DETAILS

Date : 2/7/26
Patient Name: Mst Aarib Jibraan Date of Birth: 17/11/2019 Age: 6y
Gender: Male Ward: OT UHID No.: 966899
Date of Surgery: 8/7/26 ☐ OT -1 ☐ OT -2 ☒ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2
Name of the Surgery : OGD + biopsy.

Time in : 12pm

Time Out : 12:40pm

	NAME	AMOUNT
1. Surgeon	Dr. Alisha	
2. Anaesthetist	Dr. Sunidhara	
3. Assistant Surgeon		
4. OT Technician	Kulsum	
5. Circulating Nurse	Sufata	
6. Assistant Nurse	Babir	

Special Equipment: ☐ Laparoscopy ☐ Broncoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☐ Others Endoscopy used → 9693262

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 9693262

Order by: Sufata



Upper GI Endoscopy

CONSUMABLES OF OT

Circulating staff : Technician : Date : Time : 12pm

Anaesthesia Disposables		Qty		Surgical Disposables		Qty		Disposables (Baby Side)		Qty	
Issued	Used	Issued	Used	Issued	Used	Issued	Used	Issued	Used	Issued	Used
ET tube 4.5, 5, 5.5	1/4	—		Major Pack				Inj Vit.K			
LMA 2, 2.5	0/1	—		Sutures				Cord Clamp			
ECG leads : A/P/N	0/5	3						Suction Catheter			
HME filter : A/P/N	0/1	—						Feeding Tube			
Syringes : 10 cc	1/0	4						Vaccum Suction Set			
05 cc	1/0	3		Gloves 6.6-5, 7.5 2/2	1			Surgical Gloves			
02 cc	1/0	2		FF, 6.6-5, 7.5 2/2	2			Gauze Pack			
01 cc	0/5	—						Syringe 1ml / 2ml			
Cautery plate : A/P/N	0/1	—		Surgical blade				Surgical Blade # 20			
IV set	0/1	—		NG tube				Koochies (S)			
RL	0/1	—		Cautery pencil				NS 500ml	2	1	
NS : 10ml / 100ml / 500ml / 1000ml	4/1	0		Koochies				10cc, 50cc	2/1	1	
Minipipe	0/1	1		Ointments				Jelly	1	1	
O2 mask	0/1	—		Suction Catheter				Tracheobix	1	1	
Fentanyl	0/1	1		Cap, Mask				Apron	2	—	
Morphine				Gauze Pack	4	1					
Ketamine				Mop Pack							
Propofol	0/3	2		Steristrip							
Rocuronium	0/1	—		Underpad		1	1				
Glycopyrolate	0/1	—		Draw sheet		1	1				
Myopyrolate	0/1	2		Abgel							
Ondansetron	0/1	—		Foleys catheter							
Pencan 25g/ Spinal Needle 22				Urobag				gauge + gloves	4/4	—	
Bupivacaine 0.25%	0/1	—		Chest Drainage Catheter				Dexa + Tramadol	0/1	—	
Bupivacaine 0.25% (Heavy)				Romodrain bag				Dexamed	0/1	—	
Antibiotics	0/1	—		Bandage				pmoline + 50cc	1/1	—	
				Tegaderm				ETCO2 + Nasal prong	1	1	
Suppositories				Ioban							
Anamol : 80mg / 250mg / 170 mg				Double J Stent							
Supridol : 100mg				Vaccum Suction set		1	1				
Justin : 12.5 mg / 25mg / 100mg	1/1	—		Plastic Bed Sheet		1	1				
Tab. Misoprost : 200mg				Betadine Solution		1	—				
Vaccum set	0/1	—		Microshield		1	—				
3ways 10 + 100cm	1/1	—		Cotton Balls		1	—				
O.A (10, 1)	1/1	—		Latex Gloves		10/1	—				
N.A (22, 24)	1/1	—		Ramdione Scrub							
IV Camle (22 + 24)	1/1	—		Saral							

Surgeon

Anaesthesiologist

Nurse

OT Technician

Order No. : 97693173

Ordered by :

Doc. No. : RCH / FRM / GENERAL / 125

ACTIVITY RECORD FOR BILLING

Name : _____
UHID No. : _____
Date of Admission : _____
Room / Bed No : _____ Ward : _____ Suggested Billable bed type : _____

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Dr. AISHA BABBAR



Itant: _____ Dept: _____

of Discharge : _____ Time: _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
7/7/26	3:03pm	ER	121(D)	pooja
8/7/26	11AM	121-D	OT	Ravinder
8/7/26	2pm	OT	121-D	Diya

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	video cons Dr. Chandrika	9/7/26	2694536	[Signature]
2				
3				
4				
5				
6				
7				
8				
9				
10				

[illegible]

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
07/07	IR Placement	(1)	91836	Samshy
7/7/20	NMA	(1)	91837	Samshy
8/7	PAC	(1)	9692424	Samshy

ANY OTHER INFORMATION

Date : 10/7

Time : 10 am

Prepared By : [Signature]

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
[Signature]	SLT		

ADMISSION SHEET


Registration Details :

Admission No : IP5-00176074 Admit Date : 07-Jul-2026 Admit Time : 01:40 PM UHID : BAH-00466849

Patient Details :

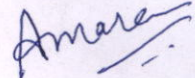
Patient Name : Master MOHAMMED AARIB JIBRAAN DECCANI Age : 6 Y 7 M 20 D
Guardian : Mr ATIF IMRAN DECCANI DOB : 17-11-2019
Gender : Male Religion :
Occupation : Martial Status : Single
Address (H) : H NO 7-853 1A, NEAR MAQBERA MASJID Phone No : 7075238360/ 7330824807
Nayamohalla Gulbarga Karnataka INDIA 585104 E-mail : NOMAIL@GMAIL.COM

Admission Details :

Bed Type : GENERAL WARD Bed No : GW121 (D) Ward Name : 1F-GENERAL WARD I
Room No : GW121 (D) Admission Type : First Visit

Contact Details :

Name : Mr ATIF IMRAN DECCANI Relationship : Father
Contact Address : H NO 7-853 1A, NEAR MAQBERA MASJID Phone No : 7075238360
Nayamohalla Gulbarga Karnataka INDIA 585104

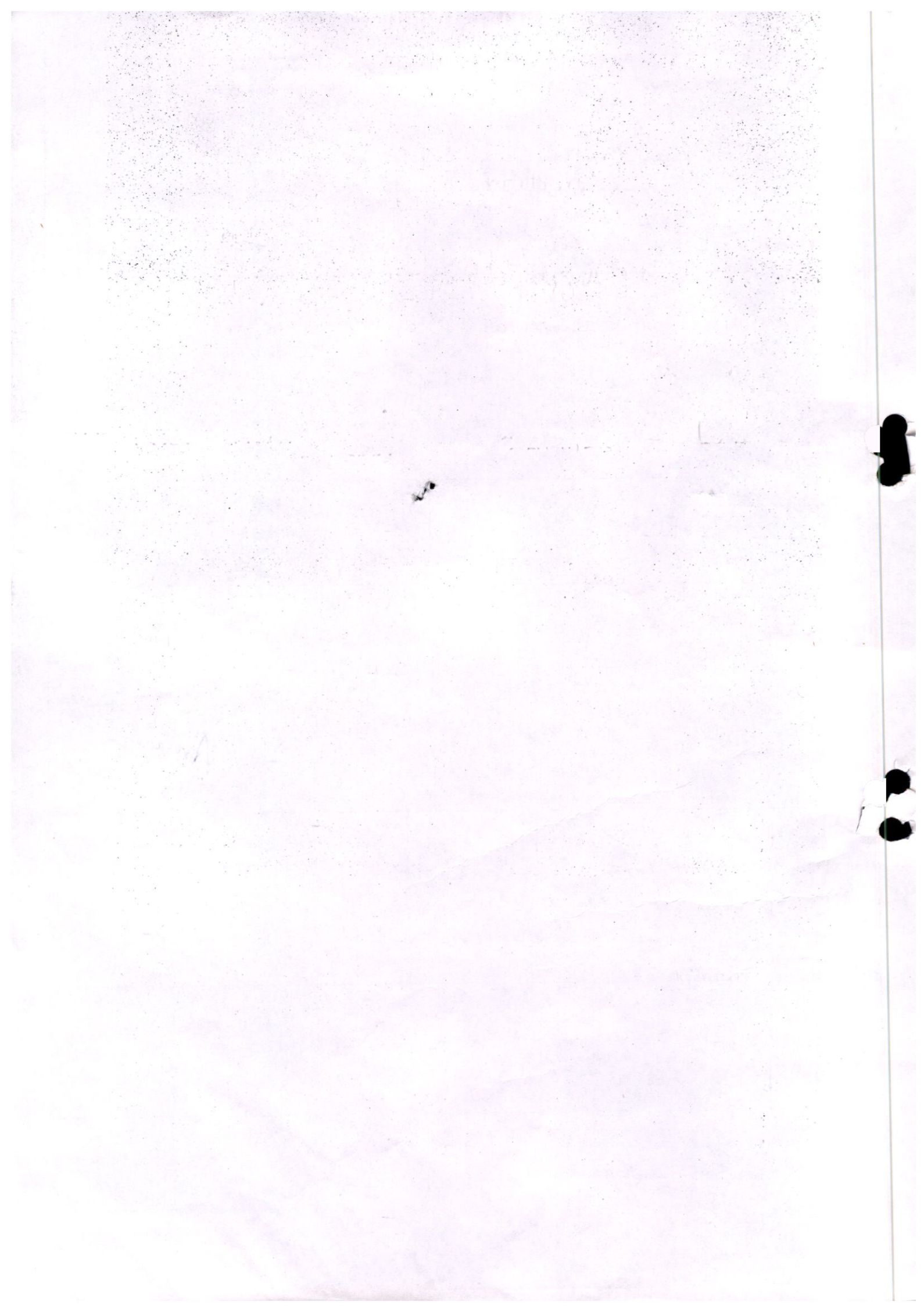

Signature

Doctor Details :

Doctor Name : Dr. ALISHA BABBAR Specialisation : PEDIATRIC GASTROENTEROLOGY AND HEPATOLOGY
Referral Doctor : Self Phone No :
Co-Consultant : Dr. Prashant Bachina/ Dr. SHAIKH FARHAN A RASHID

Payment Details :

Deposit Amount : 0.00
Payment Mode : Cash Payor Name : SELFPAY





It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

BAH-00466849 IP5-00176074
Master MOHAMMED AARIB JIBRAAN
17-11-2019 6 Y 7 M 20 D (M)
Dr. ALISHA BABBAR



Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____



Pediatric Multiorgan History & Physical Examination

Name : AAHIB JIBRAAN Age/Sex 6y / M
Information given by: _____ Relationship Mother.

Chief Presenting Complaints & Duration (Chronologically)

C/O loose stools x 20 days
C/O abdominal pain x 2 days
C/O vomiting x 2 days

History of present illness :

C/O loose stools x 20 day
↓
Initially 15-20 episodes / day
Mucus, stained, non blood stained
Watery / semi solid in consistent
Started on Oral regimine F/B DIOF-Ds
↓
Partially responded to this treatment
↓
Frequency reduced to 5-6 episodes/day.
Not passed stools for last 1 day
C/O multiple episodes of non
projectile, nonbilious vomiting x
2 days w/ intermittent
colicky abdominal pain.
USG abd (7/7/26) → S/O → Jesunitis.



Pediatric Multiorgan History & Physical Examination

Past History : (Including details of any previous investigation or treatment)

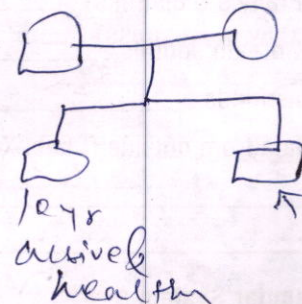
Homozygous for IL12RB1

H/O BCGosis, cervical lymphadenopathy,
skin rashes, urticaria in first 3 years
of life.

Birth & Neonatal History:

FT/NVD/CIAB/B.wt-3.2kg

NO H/O NICU admission



Birth & Socio Economic History:

About Father :

About Mother :

Any additional Information :

} upper middle class

Developmental History :

Achieved as per age in all domains

Immunization History :

Partially immunized.
~~Achieved as per~~



Pediatric Multiorgan History & Physical Examination

Anthropometry :

Head Circum (cms) _____ (Centile _____) Height (cms): _____ (Centile) _____
Weight (kgs)) 19 kg (Centile _____)

On Examination :

Temperature : 98°f Pulse Rate : 102 bpm B.P. 100/62 mmHg SPO2 100% RA
Resp. rate and type of breathing : 26 br/min

Rash _____

Lymphadenopathy _____

Oedema : _____

Allergies (if any): NKA

Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : _____

Any addles sounds : _____

Relevant data from outside (Chest X-Ray, ABG, etc.,) _____

Cardiovascular System :

Inspection of precordium : _____

Heart Sounds : _____

Any murmur : _____

Relevant data from outside (Chest X-Ray, ECG, ECHO, etc.,) : _____

Per Abdomen :

Inspection _____

Palpation : _____

Auscultation : _____

Spine : _____

External Genitalia : _____

Relevant data from outside (CT, USG etc.,) _____

USG abdomen → s/o Testicular's (07/07/20)



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness (AVPU/GCS score : 15/15

Cranial Nerves : 2

Motor System:

Nutriton : 2

Tone: 2

Power 2

Co-ordinator : 2

Posture : 2

Involuntary Movements : 2

Reflexes : 2

DTR 2

Superficials: 2

Plantars 2

Sensory System :

Bladder / Bowel : feel Bowel movements & normal bladder movements

Clinical Summary & Diagnostic:

Jejunitis with persistent diarrhea



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Shock, dehydration
Sepsis

Desired goals of the treatment :

Hemodynamic stability

Planned Labs:

CBP ✓
CRP ✓
ESR ✓
RP-2 ✓
CSF
Stool c/s
No
Shawan
#12/26

Planned Management

- WPO Till further
order
- IVF 1/2 DNS
- Inj. ceftriaxone
- Inj. Metronidazole
- Inj. Azithromycin
- Inj. Esomeprazole
- Inj. Ondansetron

Signature of the Doctor: Nalal A.

Name of the Doctor: Dr. Nandan

Date & Time: 07/07/2026, 10:30 PM

Signature of the Consultant: [Signature]

Name of the Consultant: Dr. Alisha

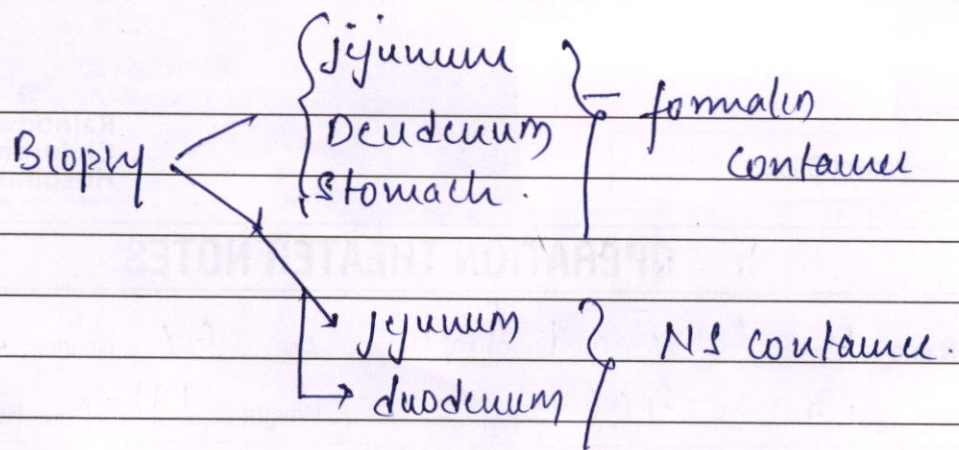
Date & Time: 07/07/2026



OPERATION THEATER NOTES

Patient's Name : Mrs. Mohammed Aareb Age : 64 Gender : ☒ Male ☐ Female
UHID No. : BAH-00466849 Weight : 19kgs Height :

Surgeon : <u>Dr. Alkha / Dr. Pouchya</u>		Asst. Surgeon :
Anesthetist :	OT Nurse :	OT Technician :
Pre-Operative Diagnosis:		
Surgical Procedure : <u>OGD + biopsy.</u>		
Indications for Surgery : <u>epicystitis / Pain abdomen / Rash.</u>		
Date : <u>8/7/26</u>	Start Time : <u>12pm</u>	End Time : <u>12:40pm</u>
Pre Operative Preparations:		
<u>NPO</u>		
Post Operative Diagnosis: <u>? Gastritis / ? infective duodenitis /</u>		
Peri-Operative Complications: <u>Nil</u> <u>& Gastritis</u>		
Operation Notes:		
<u>Esophagus - (N)</u>		
<u>Stomach - focal areas of Reddish spots & erythema.</u>		
<u>@ fundus & antrum.</u>		
<u>Duodenum - Edematous villi,</u>		
<u>Erythematous & mucosal friability</u>		
<u>Ileum - Erythema (+)</u>		
<u>friability (+).</u>		



Amount of Blood Loss: 1-2ml

Blood Transfused (in ML) Nil

Name and Number of Surgical Specimen sent for examination:

(5)

Peri-Operative Complications:

Nil.

IP Plan:

Name of the Surgeon: Dr. Powelha / Dr. Mitha

Signature of the Surgeon: for [Signature]

Date & Time:

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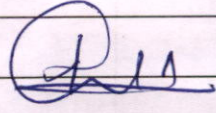
Patient:



POST-SURGICAL CARE PLAN FORM

Procedure Done: <u>OGD + biopsy</u>	
Post-Surgical Diagnosis: <u>Esophageal</u>	
Post-Operative Monitoring Parameters /Frequency: <u>1hly</u> <u>immediately</u>	
Wound Care: <u>—</u>	
n /Special Lines/Catheters: <u>—</u>	
Special Patient Positioning and Requirements: <u>—</u>	
Nutritional Instructions: <u>—</u>	
When to Start Mobilization: <u>immediately</u>	
Special Referrals: <u>—</u>	
The new order for all required medications documented in the doctor order/medication sheet: ☐ Yes ☐ No	
Any Other Post-Operative Care Needed including Required Follow Up <u>for</u>	
Treating Surgeon (Signature & Stamp) <u>[Signature]</u>	Date: Time:
Note: Plan of care will be readjusted if necessary.	

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
07/09/26 6pm	C/S/B - Gastro Team Persistent pain abdomen - jejunal. No Vomiting crampy type pain abdomen (+) No acthike. No passed stool < 1/day No Rash No lymphadenopathy No fever. o/e - Hemodynamically stable Chest - clear P/A - Soft, Mild - Not tenderness B.S (+). CNS - NND	Plan 1x Albumin + in same sample CSE, CUE. 2x Drug as per chart. 3x IV fluids as advised 4x UGI Endoscopy Tfm. ↓ 12 PM + NPO from 6 AM morning. + 5x Allow liquids if accepting orally
		

(P.T.O)



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
08/07/20 9AM	cl/B. Gallo Team MSHD - IL12BR # jejunite. Rach (2) Post op - Pericardial dissection No pain abdomen No vomiting Rach. over face, Trunk, limb. (UL & LL) Blanchable, Not tender, Non itchy, Erythematous (urticarial like) lesions. U/E - vitals stable Chest - clear P/A - soft, Not tender CNS - WAD Stool - Not passed yesterday <u>9 HSP</u>	<u>Plan</u> 1x NPO + Endoscopy @ 12PM 2x IV fluids - to continue 3x Daily apex chart 4x Trace Bile. 5x monitor vitals. 6x Rx regarding starting steroids
		<i>[Signature]</i> Dr. Kumpf

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
07/12/26 1 PM	C/S/B - Gastro Team	O/w. Dr. Aisha
	<u>Plan</u>	
	1x To send	
	Blood culture & sensitivity	
	2x Biopsy - formalin	
	sample for HPE	
	3x To keep. NS contains biopsy	
	sample with hospital	
	for further advise	
	4x To discuss	Dr. Kumar
	steroids after	<u>Plan</u>
	sending B/C	
8 PM		<u>Plan</u>
		1x Atarax lotion for I/A
		2x Atarax syrup
		5ml/TID.



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
08/07/20 4 PM	C/S/B - Gastro team	
	MSMO - IL12RB1 #	Plan
	Jejunite / Nasal tube Ralt	1x IV fluids - DNS - full maintenance
	No pain abdomen	2x Thrombophobe ointment for UA.
	Stools passed day before yesterday	
	Oral intake - low.	3x Strict NPO mouth only
	NPO - last passed 3 AM today	4x Allow soft diet
	O/E - Conscious, Afebrile	
	Hemodynamic stable	5x Decide on starting steroids.
	Chest -	6x Rheumatology consultation
	Passed urine in diaper.	
	102/70 mmHg	To hold till further advice
6 PM	C/S/B - Dr. Alisha	7x Add Ceftriaxone.

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
09/07/20	C/S/B - Gastro Team	
9 AM		
	MSMD ILI2RB, #	Plan
	Jejunitis/ Varicella Rash.	
		1x Dext and
(1)	40 stools - small quantity	IV fluids to continue
	Mucus + Blood, painful defecation	
(2)	Rash - confluent, generalised	2x monitor vitals
	erythema	3x Trace B/C/S report
(3)	↓ oral intake	& Biopsy
(4)	40 feeling of swelling	for EBV/ATB
	of face & limbs	4x Rheumat
	up - adequate	consultation.
	o/c - Hemodynamic	5x TPlan - steroids on
	stable	sounds.
	I/A - soft, Not tender	
	BS (+)	
	CNS - NAD	Plan
	Generalised erythema over	to send
	face.	CBC & ESR
	Minimal face swelling.	urea & creat
		Plan
		Collect reports
		(3) BP monitoring q 6-8 hrs

Date & Time	Progress Notes	Doctor's Order
11 AM		<u>Plan</u>
09/07/26		1x Oral steroids x 5 days add after culture.
4 PM	C/S/B - Gastro team	
	MISMD - IL-12RB1 #	
	Joints / Variable Rash.	
	Pain abdomen - ↓	<u>Plan</u>
	No Mucous / Blood in stool	1x Plan drug aspects
	O/E - Hemodynamically stable	2x w/ progression of rash & Blood in stool
	Chest - clear	3) monitor vitals
	P/A - soft	

~~10/10/2026~~
~~9pm~~

[Handwritten signature]

OPD Summary

UHID	BAH-00466849	Visit No	040267-156272
Patient Name	Master MOHAMMED AARIB JIBRAAN	Visit Date	09-07-2026 11:40 AM
DOB / Age /	17-11-2019 / 6 Y 7 M 22 D / Male	Consultation	Non Doctor Visit
Doctor Name	Dr. CHANDRIKA S BHAT		
Department	LABORATORY		
Specialization			

Present Illness :

Diarrhoea for 2 weeks

Pain abdomen - periumbilical - subsequently vomiting

USG - jejunitis

Endoscopy - Inflm changes

Now has developed itchy red rash , with periorbital puffiness

Stopped colchicine one yr ago- on homeopathy medications now

Past History :

Whole exome sequencing IL12RB1 exon 10 c1102T>C Homozygous (VUS)

IL12RB1 predisposes to MSMD phenotype and can have tuberculosis/salmonellosis.

Examination :

Video consultation

Diagnosis :

IL12RB1 can predispose to leucocytoclastic vasculitis. Usually these episodes are triggered by an intercurrent infection viz salmonella/TB/NTM.

Doctor Recommendations :

1. Start IVMP 1mg/kg once a day for 5 days
2. Sanger sequencing of parents
3. Continue antimicrobials (to cover salmonella, suggest adding azithromycin) for one week
4. Should there be recurrent flares plan to start colchicine/AZA

Dr. CHANDRIKA S BHAT

MD, Fellowship in Paediatric Rheumatology (Bristol, UK)
Consultant, Paediatric Rheumatology, Immunology And
Paediatric Immune Dysregulation Services
86597

** This Card is Valid upto 09-07-2026 or First Visit - Which ever is the earliest **



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 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

RESULT SHEET

Date	7/7/26				
Time					
Hb	13.1	12.2			
PCV	40.3	38			
RBC	5.33	4.9			
WBC	13780	16200			
N/L	81/13	65/30			
Platelets	4.9 L	4.5			
CRP	12				
ESR	34				
PCT					
RBS					
Na	135				
K	4.6				
Cl	99				
Ca/Mg					
Phosphate					
Urea	23	25			
Creatinine	0.4	0.5			
ALP					
SGPT					
SGOT					
T.Bill/Conj					
T.Protein					
S.Albumin	5				
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L	1405	22			

Date						
Time						
CUE - Alb	Trace -					
CUE - Sugar	Nil					
CUE - Ketones	2-3					
CUE - PUS Cells	4-5					
CUE - RBC Cells	0.					
CUE Ketone	+3					
Nitrate	} Negative					
Blood						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
	Scraped.					
Mucous (+)						
Blood (-)						
undigested (+)						
food						
Pus cells 3-4						
RBC 2-3						
starch (+)						
yeast +3						
fat globule (+)						

Culture and Sensitivities :

Genexpt of biopsy sample
 ↳ Negative

Radiology : USG :

X-Ray :

ECHO :

CT :

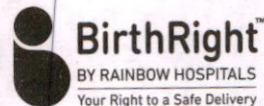
MRI :

Others (ECG, Contrast Studies etc.,) :

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mib jibran



MEDICATION RECONCILIATION FORM

Drug Allergies: ☒ Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.

(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: ICU Shifted to: ward

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1						☐ C ☐ DC
2						☐ C ☐ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Dr. Nandan

Date & Time: 07/07/2026, 1:20 PM

Nurse Name & Signature: poorja

Date & Time: 07/07/26 e 1:30 pm

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Sheet No:

REGULAR PRESCRIPTIONS

Weight 19 kg • Ward

DRUG: INS. ESDONEPRAZOLE				Date Time
Dose <u>10</u>	Route	Frequency	Start Dt.	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG: <u>INS. ONDANSETRON</u>				Date Time <u>07/07 8/7 9/7 10/7</u>
Dose <u>3mg</u>	Route <u>IV</u>	Frequency <u>TID</u>	Start Dt. <u>7/7/2020</u>	
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Nandan</u>				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG: <u>Syp. AZITHROMYCIN</u>				Date Time <u>7/7 8/7 9/7</u>
Dose <u>5ml</u>	Route <u>PO</u>	Frequency <u>OD</u>	Start Dt. <u>7/7</u>	
Name & Signature of the Doctor Starting the Drugs: <u>Sachin</u>				
Additional Instructions: <u>(5ml/200mg)</u>				
Daily Doctor's Endorsement by a Sign				
DRUG: <u>ly Tramadol</u>				Date Time
Dose <u>15mg</u>	Route <u>PO</u>	Frequency <u>BD</u>	Start Dt. <u>07/07</u>	
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Kumar</u>				
Additional Instructions: <u>if 40 pain abdomen</u>				
Daily Doctor's Endorsement by a Sign				

Signature

VERIFIED BY: Name

BAH-00466849 IP5-00176074
Master MOHAMMED AARIB JIBRAAN
17-11-2019 8 Y 7 M 20 D (M)
Dr. ALISHA BABBAR



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Sheet No:

REGULAR PRESCRIPTIONS

DRUG : SYP. ATARAX

Dose 4ml Route PO Frequency TID Start Dt. 08/07

Date/Time 8/7/10

Name & Signature of the Doctor Starting the Drugs:

[Signature]

Additional Instructions:

(5ml/10mg)

Daily Doctor's Endorsement by a Sign

DRUG : Atarax lotion for

Dose local Route application Frequency TID Start Dt. 08/07

Date/Time 8/7/10

Name & Signature of the Doctor Starting the Drugs:

Dr. Kumar

Additional Instructions:

Local application

Daily Doctor's Endorsement by a Sign

DRUG : T. CETRIXINE

Dose 1 tab Route PO Frequency OD Start Dt. 08/07

Date/Time 8/7/10

Name & Signature of the Doctor Starting the Drugs:

Dr. Kumar

Additional Instructions:

1 tab = 10mg

Daily Doctor's Endorsement by a Sign

DRUG : THROMBOPHORE

Dose local Route application Frequency BD Start Dt. 08/07

Date/Time 8/7/10

Name & Signature of the Doctor Starting the Drugs:

[Signature]

Additional Instructions:

over 12 foramen
canal side

Daily Doctor's Endorsement by a Sign

Docu. No. : RCHBH / FRM / CLINICAL / 108

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Master MOHAMMED AARIB JIBRAAN
17-11-2019 6 Y 7 M 23 D (M)
Dr. ALISHA BABBAR



Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

DRUG : LABOMNOLOLIL				Date Time 09/7															
Dose 10mg	Route PO	Frequency BD	Start Dt. 09/07																
Name & Signature of the Doctor Starting the Drugs: Dr. Kunal				10AM X															
Additional Instructions: (1 tab = 10mg)				10PM 5PM prn															
Daily Doctor's Endorsement by a Sign																			
DRUG : Calanue lotion				Date Time 09/07															
Dose 10ml	Route TID	Frequency TID	Start Dt. 09/07																
Name & Signature of the Doctor Starting the Drugs: Dr. Kunal				6AM X ✓															
Additional Instructions: for local application				10PM ✓															
Daily Doctor's Endorsement by a Sign																			
DRUG :				Date Time															
Dose	Route	Frequency	Start Dt.																
Name & Signature of the Doctor Starting the Drugs:																			
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign																			
DRUG :				Date Time															
Dose	Route	Frequency	Start Dt.																
Name & Signature of the Doctor Starting the Drugs:																			
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign																			

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 Master MOHAMMED AARIB JIBRAAN
 17-11-2019 6 Y 7 M 23 D (M)
 Dr. ALISHA BABBAR



Sheet No:

REGULAR PRESCRIPTIONS

Weight Ward

DRUG :				Date Time																
Dose	Route	Frequency	Start Dt.																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

DRUG :				Date Time																
Dose	Route	Frequency	Start Dt.																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

DRUG :				Date Time																
Dose	Route	Frequency	Start Dt.																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

DRUG :				Date Time																
Dose	Route	Frequency	Start Dt.																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

Signature
VERIFIED BY : Name



arib JIBRAAN

DRUG CHART

Date of Admission: 07/07/20 Drug Allergies: ☒ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

- GENERAL** - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.
- DOCTOR** - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
- Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
- Discontinue a drug by drawing a line **I** through it and a similar line through subsequent recording panels.
- The date and time of stopping the drug along with the doctors name and sign must be mentioned.
- Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.
- NURSES** - Nurses must follow strictly the FIVE RIGHTS before administration of medication.
1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
- AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

DRUG : Inj BUSOPAN				Date Time															
Dose	Route	Frequency	Start Date																
12mg	IV	TID (800)	07/07																
Doctor's Signature		Valid Period	Pharm.																
Additional Instructions:																			
if 40pam abdomen																			

DRUG : Inj PARACETAMOL				Date Time															
Dose	Route	Frequency	Start Date																
Doctor's Signature		Valid Period	Pharm.																
Additional Instructions:																			

DRUG : SYPCROINDS				Date Time															
Dose	Route	Frequency	Start Date																
5mg	PO	TID (800)																	
Doctor's Signature		Valid Period	Pharm.																
Additional Instructions:																			
if 40pam abdomen																			
not reducing																			



REGULAR PRESCRIPTIONS

Weight. 19 Kg Ward.

DRUG : INS. CEFTRIAXONE				Date Time	7/7	8/7	9/7	10/7
Dose	Route	Frequency	Start Date					
950mg	IV	BD	07/07/26					
Name & Signature of the Doctor Starting the Drugs: <i>Dr. Nandan</i>				GAM X pran sona sona				
Additional Instructions:				4PM 6PM pran sona sona start see pran				
Daily Doctor's Endorsement by a Sign								
DRUG : INS. METRONIDAZOLE				Date Time	7/7	8/7	9/7	10/7
Dose	Route	Frequency	Start Date					
190mg	IV	TID	7/7/26	GAM X pran sona sona				
Name & Signature of the Doctor Starting the Drugs: <i>Dr. Nandan</i>				4PM 2PM pran sona sona start see pran				
Additional Instructions:				10PM pran sona sona start see pran				
Daily Doctor's Endorsement by a Sign								
DRUG : INS. AZITHROMYCIN				Date Time				
Dose	Route	Frequency	Start Date					
190mg	IV	OD	7/7/26					
Name & Signature of the Doctor Starting the Drugs: <i>Dr. Nandan</i>				STOP changed pran sona				
Additional Instructions:				7/7				
Daily Doctor's Endorsement by a Sign								
DRUG : INS. ESOMEPRAZOLE				Date Time	7/7	8/7	9/7	
Dose	Route	Frequency	Start Date					
20mg	IV	OD	7/7/26	GAM pran sona sona				
Name & Signature of the Doctor Starting the Drugs: <i>Dr. Nandan</i>				pran sona Arum				
Additional Instructions:								
Daily Doctor's Endorsement by a Sign								



Weight. 19 Kg Ward.

VARIABLE DOSE		Date Time	Nurse Sig.	Nurse Sig.	Nurse Sig.	Nurse Sig.
DRUG :		Dose		Dose		Dose
		Dr. Sign.		Dr. Sign.		Dr. Sign.
Route	Start Date	Dose		Dose		Dose
		Dr. Sign.		Dr. Sign.		Dr. Sign.
Name & Signature of the Doctor		Dose		Dose		Dose
		Dr. Sign.		Dr. Sign.		Dr. Sign.
Additional Instructions:		Dose		Dose		Dose
		Dr. Sign.		Dr. Sign.		Dr. Sign.

VARIABLE DOSE		Date Time	Nurse Sig.	Nurse Sig.	Nurse Sig.	Nurse Sig.
DRUG :		Dose		Dose		Dose
		Dr. Sign.		Dr. Sign.		Dr. Sign.
Route	Start Date	Dose		Dose		Dose
		Dr. Sign.		Dr. Sign.		Dr. Sign.
Name & Signature of the Doctor		Dose		Dose		Dose
		Dr. Sign.		Dr. Sign.		Dr. Sign.
Additional Instructions:		Dose		Dose		Dose
		Dr. Sign.		Dr. Sign.		Dr. Sign.

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
07/07/26	1:30 PM	IND. BUSCOBAN	10mg	IV	Handwritten signature	Lehala Pooja
7/7/26		Supj TRAMADOL	20mg	IV	Handwritten signature	Hard
7/7/26	4:38 PM	INT. PARALCTAMOL	250mg	IV	Handwritten signature	Shantika Poojila
8/7/26	6:00 AM	Supj AVIL	10mg	IV		Prav
8/7/26	8:10 AM	Supj HYDROCORTISONE	40mg	IV		Omigade
9/7	7:45 AM	Supj AVIL	10mg	iv	Handwritten signature	Sona Chandra



I.V. FLUIDS CHART

Weight. 19kg Ward.

[illegible]

BAH-0046649
Master MOHAMMED AARIB JIBRAAN
17-11-2019 6 Y 7 M 23 D
Dr. ALISHA SABBAR (M)



... : RCHBH/ FRM / CLINICAL / 126

SCHOOL AGE (5-12 years)

Children's Observation &
Early Warning Scoring Chart

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 10/7/20	Time: 2AM	6AM
Doctor / Nurse / Family Concern?		
Temperature (°F)	98.4	98.2
Heart Rate (bpm)	120	120
Blood Pressure (mmHg) *	100/70	100/70
Heart Rate (Number)	120b/m	120b/m
Resp. Rate (bpm) (Over 1 Minute) *	28	28
Resp Rate (Number)	28b/m	28b/m
Resp Mod/ Severe Distress None / Mild		
Receiving O ₂ (l/min)		
O ₂ Saturations (%)	99	99
Conscious Level Normal / Altered		
GCS *	15/15	15/15
TOTAL SCORE	1	1
Number of shaded boxes	1	1
Pain Score	0	0
Observer's Initials	O	O

ACTIONS

NB: Scores 3 should be recorded overleaf

- Score 1 : Continue normal observation by staff nurse
- Score 2 : Shift in charge nurse to be informed and continue hourly observations
- Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
- Score 4 : Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see
- Score 5 & 6 : Shift in charge AND PICU fellow or PICU consultant to be informed.

* NB: If GCS is below 12 or the Oxygen requirement is >3 Lit./min. , then irrespective of rest of the score, the Nurse MUST inform the PICU team.

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

- The paediatric Early Warning Score i) seeks to identify the abnormal physiological finding seen during serious childhood illnesses and ii) offers a method to interpret such physiological derangements with clearly defined actions, ensuring that suitably experienced staff are involved with the care of the sickest children.
- The Early Warning Score does not replace clinical experience and acumen and should not be relied upon for such purpose.
- 6 clinical parameters are assessed and recorded as part of the child's routine clinical observation, providing a Early Warning Score between 0-6 (Higher Early Warning Score are seen in sicker children)
- Detailed actions are described according to increasing Early Warning Score.
- Some children with complex medical needs e.g. cyanotic heart disease may require modification to their trigger thresholds/ action plan- this should follow discussion with senior colleagues.
- Any Early Warning Score of 3 or above should be recorded below with details of any subsequent action initiated

Record Details when EARLY WARNING SCORE > 3			Record Time of Review and Plan		
Date	Time	Early Warning Score	Date	Time	Name

- If at any time additional help is required, call help – regardless of the Early Warning Score!
- Following a Early Warning Score assessment, senior help may be required

The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

I	IDENTITY: I am (name), a nurse on ward (X). I am calling about (child X)
S	SITUATION : I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	BACK GROUND : Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free)
A	ASSESSMENT : I think the problem is (XXX) and I have ... (e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
R	RECOMMENDATION : I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)



EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 9/2/26	Time:	6am	10am	2pm	6pm	10pm	2am
Doctor / Nurse / Family Concern?							
Temperature (°F)	104						
	103						
	102						
	101						
	100						
	99						
	98						
	97						
	96						
	95						
94							
Heart Rate (bpm)	190						
	180						
	170						
	160						
	150						
	140						
	130						
	120						
	110						
	100						
Blood Pressure (mmHg) *	90						
	80						
	70						
	60						
	50						
	40						
	30						
	20						
	10						
	0						
Note: BP does not score in early warning scoring							
Heart Rate (Number)	116/m	103/m	124/m	122/m	130/m		
p. Rate (bpm) (Over 1 Minute) *	70						
	60						
	50						
	40						
	30						
	20						
	10						
	0						
	Resp Rate (Number)	26/m	26/m	26/m	22/m	28/m	
	Resp Distress	Mod/ Severe	None / Mild				
Receiving O ₂ (l/min)	99%	100%	100%	99%	99%		
O ₂ Saturations (%)	99%	100%	100%	99%	99%		
Conscious Level	Normal	Altered					
GCS *	15/15	15/15	15/15	15/15	15/15		
TOTAL SCORE							
Number of shaded boxes	0	1	1	1	1		
Pain Score	0	0	0	0	0		
Observer's Initials	Q						

ACTIONS

NB: Scores 3 should be
recorded overleaf

- Score 1 : Continue normal observation by staff nurse
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A	ASSESSMENT : I think the problem is (XXX) and I have ... (e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
R	RECOMMENDATION : I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

BAH-00466849 IP5-00176074
 Master MOHAMMED AARIB JIBRAAN
 17-11-2019 8 Y 7 M 20 D (M)
 Dr. AJSHA BABBAR

Doc. No. : RCHBH/ FRM / CLINICAL / 126

SCHOOL AGE (5-12 years)

Children's Observation &
 Early Warning Scoring Chart

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 8/7	Time:				
Doctor / Nurse / Family Concern?	10 am	2 pm	5 pm	6 pm	10 pm 2 am
Temperature (F)	98.9			99.0	98.9
Heart Rate (bpm)					
Blood Pressure (mmHg) *	100/60		102/60	108/60	100/60
Heart Rate (Number)	117b/m		103bpm	125bpm	101b/m
Resp. Rate (bpm)					
Resp Rate (Number)	26b/m		26b/m	26b/m	26b/m
Receiving O ₂ (l/min)					
O ₂ Saturations (%)	100%		100%	100%	99%
Conscious Level	15/15		15/15	15/15	15/15
GCS *	15/15		15/15	15/15	15/15
TOTAL SCORE	1		1	1	0
Number of shaded boxes	1		1	1	0
Pain Score	0		0	0	0
Observer's Initials					

ACTIONS

NB: Scores 3 should be recorded overleaf

Score 1 : Continue normal observation by staff nurse

Score 2 : Shift in charge nurse to be informed and continue hourly observations

Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.

Score 4 : Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see

Score 5 & 6 : Shift in charge AND PICU fellow or PICU consultant to be informed.

* NB: If GCS is below 12 or the Oxygen requirement is >3 Lit./min. , then irrespective of rest of the score, the Nurse MUST inform the PICU team.

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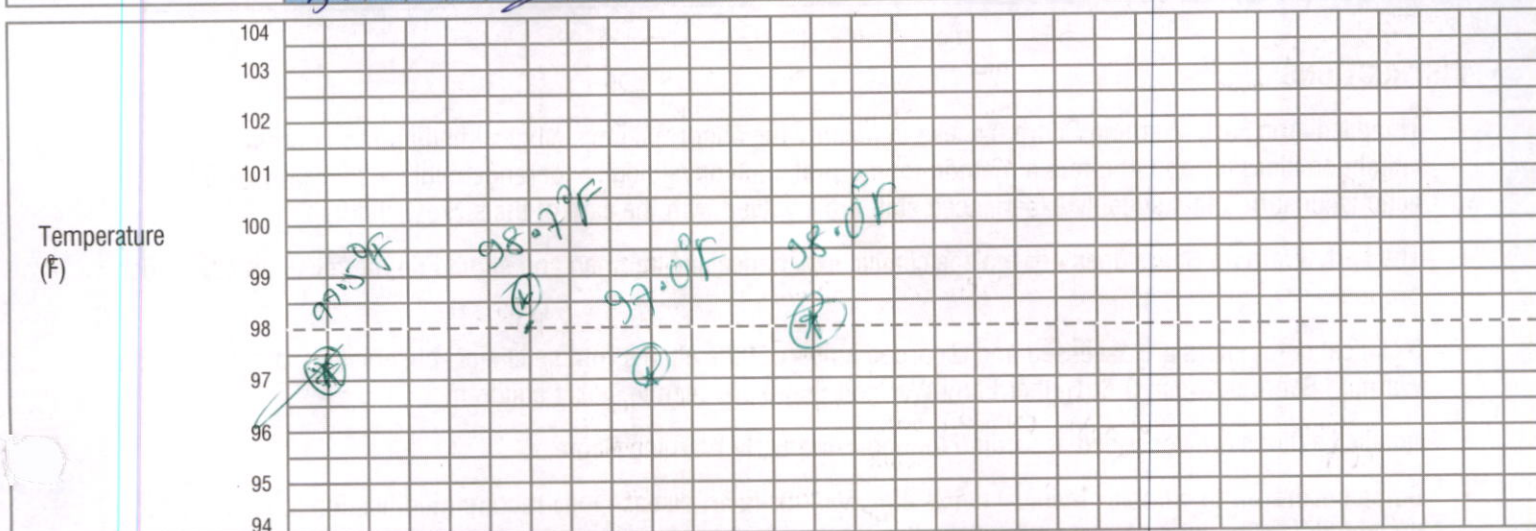
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R	RECOMMENDATION : I need you to ... come to see the child in the next (XX mins) AND Is there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)



SCHOOL AGE (5-12 years)
Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 7/12/20 Time: 3:00pm 10PM 2AM 6AM
Doctor / Nurse / Family Concern?



Heart Rate (bpm) and Blood Pressure (mmHg) *

Note: BP does not score in early warning scoring

Time	Heart Rate (bpm)	Blood Pressure (mmHg)
3:00pm	102	111/80
10PM	102	102/73
2AM	110	103/63
6AM	106	108/63

Heart Rate (Number)

102bpm 102bpm 110bpm 106bpm

Resp. Rate (bpm) (Over 1 Minute) *

Time	Resp. Rate (bpm)
3:00pm	25
10PM	21
2AM	26
6AM	24

Resp Rate (Number)

25bpm 21bpm 26bpm 24bpm

Resp Mod/ Severe Distress None / Mild

Receiving O₂ (l/min) O₂ Saturations (%)

100% 98% 100% 98%

Conscious Level Normal Altered

GCS *

15/15 15/15 15/15 15/15

TOTAL SCORE

Number of shaded boxes

1 1 1 1

Pain Score

0 0 0 0

Observer's Initials

D A A A

ACTIONS

NB: Scores 3 should be recorded overleaf

Score 1 : Continue normal observation by staff nurse
Score 2 : Shift in charge nurse to be informed and continue hourly observations
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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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Date	Time	Early Warning Score	Date	Time	Name

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B	BACK GROUND : Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free)
A	ASSESSMENT : I think the problem is (XXX) and I have ... (e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
R	RECOMMENDATION : I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

Patient

BAH-00466849
Master MOHAMMED AARIS JIBRAAN
17-11-2019 8 Y 7 M 20 D (M)
Dr. ALISHA BASBAR



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FLUID CHART

Sheet No. : ①

1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine				
			Mouth	I.V	N.G								
	08:00 am					/							
	09:00 am					/							
	10:00 am					/							
	11:00 am					/							
	12:00 pm					/							
	01:00 pm					/							
Total Intake :						Total Output :							
7/7	02:00 pm					/							
	03:00 pm					/							
	04:00 pm	1/2		60ml		/							
	05:00 pm	1/2		60ml		/							
	06:00 pm	1/2		60ml		/							
	07:00 pm	1/2		60ml		/							
Total Intake :						Total Output :							
7/7	08:00 pm	1/2	juice	60ml		/							
	09:00 pm	1/2	juice	60ml		/							
	10:00 pm	1/2	juice	60ml		/							
	11:00 pm	1/2	water	60ml		/							
	12:00 am	1/2	water	60ml		/							
	01:00 am	1/2	water	60ml		/							
Total Intake :						Total Output :							
8/7	02:00 am	1/2		60ml		/							
	03:00 am	1/2		60ml		/							
	04:00 am	1/2		60ml		/							
	05:00 am	1/2		60ml		/							
	06:00 am	1/2	NPO	60ml		/							
	07:00 am	1/2	NPO	60ml		/							
Total Intake :						Total Output :							
Total 24 hrs. Intake						Total 24 hrs. Output							



FLUID CHART

Sheet No. ④

1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.
3. 24 hrs. total to be entered in the kardex in RED.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
8/7	08:00 am			60ml	-	-	-	-	-	-	0	[Signature]	
	09:00 am	± 20mls	NPO	60ml	-	-	-	-	-	-	0		
	10:00 am			60ml	-	-	-	-	-	-	0		
	11:00 am				-	-	-	-	-	-	0		
	12:00 pm				-	-	-	-	-	-	0		
	01:00 pm				-	-	-	-	-	-	0		
Total Intake :						Total Output :							
8/7	02:00 pm	↑		60ml	/	/	/	/	/	0	[Signature]		
	03:00 pm		Kididi	60ml	/	/	/	/	/	0			
	04:00 pm	ONE		-	/	/	/	/	/	0			
	05:00 pm			60ml	/	/	/	/	/	0			
	06:00 pm			60ml	/	/	/	/	/	0			
	07:00 pm	↓		60ml	/	/	/	/	/	0			
Total Intake :						Total Output :							
8/5	08:00 pm			55ml	/	/	/	/	/	0	[Signature]		
	09:00 pm			55ml	/	/	/	/	/	0			
	10:00 pm	ONS	Meat	55ml	/	/	/	/	/	0			
	11:00 pm		water	55ml	/	/	/	/	/	0			
	12:00 am			55ml	/	/	/	/	/	0			
	01:00 am			55ml	/	/	/	/	/	0			
Total Intake :						Total Output :							
9/5	02:00 am			55ml	/	/	/	/	/	0	[Signature]		
	03:00 am			55ml	/	/	/	/	/	0			
	04:00 am	ONS		55ml	/	/	/	/	/	0			
	05:00 am			55ml	/	/	/	/	/	0			
	06:00 am			55ml	/	/	/	/	/	0			
	07:00 am			-	/	/	/	/	/	0			
Total Intake :						Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output

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17-11-2019 6 Y 7 M 23 D (M)
Dr. ALISHA BASSAR

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FLUID CHART

Sheet No. : 13

- All measurements in ml.
- Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
9/5	08:00 am	DNS	cwd	55ml	/	/	NP	/	/	NP	0	R
	09:00 am			55ml							0	
	10:00 am			-							0	
	11:00 am			-							0	
	12:00 pm			55ml							0	
	01:00 pm			-							0	
Total Intake :					Total Output :							
9/5	02:00 pm	DNS	/	55ml	/	/	NP	/	/	/	6	Aliki
	03:00 pm			55ml							0	
	04:00 pm			55ml							0	
	05:00 pm			55ml							0	
	06:00 pm			-							0	
	07:00 pm			-							0	
Total Intake :					Total Output :							
10/7	08:00 pm	DNS	10/4	55ml	/	/	/	/	/	/	0	Rama
	09:00 pm			55ml							0	
	10:00 pm			55ml							0	
	11:00 pm			55ml							0	
	12:00 am			55ml							0	
	01:00 am			55ml							0	
Total Intake :					Total Output :							
10/7	02:00 am	DNS	/	55ml	/	/	/	/	/	/	0	Rama
	03:00 am			55ml							0	
	04:00 am			55ml							0	
	05:00 am			55ml							0	
	06:00 am			55ml							0	
	07:00 am			55ml							0	
Total Intake :					Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output

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FLUID CHART

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Sheet No. :

1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.
3. 24 hrs. total to be entered in the kardex in RED.

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						Total Output :						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						Total Output :						

Total 24 hrs. Intake

Total 24 hrs. Output



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 7/07/26

Assessment: Pt having no fever

- Goals
- ☐ Maintain Airway and Oxygenation
 - ☐ Relieve Pain & Discomfort
 - ☐ Maintain Fluid Balance
 - ☐ Improve Activity Tolerance
 - ☐ Maintain Good Nutritional Status
 - ☐ Maintain Skin Integrity
 - ☐ Maintain Personal Hygiene
 - ☒ Prevent Infection
 - ☐ Meet Elimination Needs
 - ☒ Ensure Safety
 - ☐ Early Ambulation Reduce Anxiety
 - ☒ Patient & Family Education
 - ☐ Identify Potential Complications
 - ☐ Any Others. Specify.....

Time	Plan of Care	Time	Implementation	Evaluation
2pm	* Assess the pt General Condition	2:30 pm	* Assessed the pt General condition	
3pm	* check the pt air vitals	3:30 pm	* checked the pt air vitals	
4pm	* maintain supine chest	4:30 pm	* maintained supine chest	
5pm	* provide comfortable position	6pm	* provided comfortable position	
7pm	* administer oral medication	8pm	* administered oral medication	
	Given as per doctor order		Given as per doctor order	Pt is stable

Re-Assessment:

Special Notes: continue w/o liquids allowed from case admin sending

Nurse Signature:

Nurse Name: Shanthi

Date & Time: 7/07/26 8pm

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NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 7/7/26

Assessment: Abdominal pain

Goals

- ☒ Maintain Airway and Oxygenation
- ☒ Relieve Pain & Discomfort
- ☒ Maintain Fluid Balance
- ☐ Improve Activity Tolerance
- ☐ Maintain Good Nutritional Status
- ☐ Maintain Skin Integrity
- ☒ Maintain Personal Hygiene
- ☒ Prevent Infection
- ☐ Meet Elimination Needs
- ☒ Ensure Safety
- ☐ Early Ambulation Reduce Anxiety
- ☐ Patient & Family Education
- ☐ Identify Potential Complications
- ☐ Any Others. Specify.....

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess general condition of the patient.	8:40 pm	Assessed general condition of the patient.	By line as implementation, as per doctor's order.
10pm	Monitor vital signs.	10pm	Monitor vital signs.	
11pm	Provide comfortable position to the patient.	11pm	Provided comfortable position.	
6 AM	Provide information about NPO status.	6 AM	Provided education.	
7 AM	Provide liquid base diet.	7 AM	Provided liquid diet only.	

Re-Assessment: Upper GI endoscopy - 12pm

Special Notes: NPO from - 6 AM (liquids diet)

Nurse Signature: P.B. Nurse Name: Poojanka Date & Time: 8/7/26 8 AM



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 8/7

Assessment:

Acute pain & Discomfort

Goals

- | | | | | | |
|---|---|---|---|--|--|
| ☐ Maintain Airway and Oxygenation | ☒ Relieve Pain & Discomfort | ☐ Maintain Fluid Balance | ☐ Improve Activity Tolerance | ☒ Maintain Good Nutritional Status | ☐ Maintain Skin Integrity |
| ☐ Maintain Personal Hygiene | ☐ Prevent Infection | ☐ Meet Elimination Needs | ☐ Ensure Safety | ☐ Early Ambulation Reduce Anxiety | ☒ Patient & Family Education |
| ☐ Identify Potential Complications | ☐ Any Others. Specify..... | | | | |

Time	Plan of Care	Time	Implementation	Evaluation
12:50	Assess the pt General Condition.	12:55	Assessed the pt General Condition.	pt is Conscious & oriented
1m	Relieve pain & Discomfort	1:5m	Relieved pain & Discomfort	oriented
1:10	monitor vital signs	1:15	monitored vital signs	& vital stable
1:20	monitor for bleeding	1:25	monitored for bleeding	& no bleeding
1:30	maintain I/O chart	1:35	maintained I/O chart	& maintained
1:40	maintain NPO status	1:45	NPO broken, water given	& no Vomiting
1:50	pt shift to the ward	2pm	pt shift to the ward	

Re-Assessment:

After surgery procedure pt is Conscious & oriented

Special Notes:

Nurse Signature: 

Nurse Name: Ansh

Date & Time: 8/7/26

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 8/12

Assessment: pt having Discomfort

Goals

- | | | | | | |
|---|---|--|---|--|--|
| ☒ Maintain Airway and Oxygenation | ☐ Relieve Pain & Discomfort | ☒ Maintain Fluid Balance | ☐ Improve Activity Tolerance | ☒ Maintain Good Nutritional Status | ☐ Maintain Skin Integrity |
| ☒ Maintain Personal Hygiene | ☒ Prevent Infection | ☐ Meet Elimination Needs | ☒ Ensure Safety | ☐ Early Ambulation Reduce Anxiety | ☒ Patient & Family Education |
| ☐ Identify Potential Complications | ☐ Any Others. Specify..... | | | | |

Time	Plan of Care	Time	Implementation	Evaluation
8pm	→ Assess the pt General Condition	8:10pm	→ Assessed the pt General Condition	pt is stable
10pm	→ Check the Vital Signs	10:10pm	→ Checked the Vital Signs	
12am	→ plan for Administration medication	12:10am	→ Providing medication as per doctor	
2am	→ plan for S/o Chart	2:10am	→ strictly S/o Chart	
8am	→ plan for Comfortable position → plan for Ensure Safety	8:10am	→ providing Comfortable position	

Re-Assessment: Re-Assessment Every 4th hrly

Special Notes:

Nurse Signature:

[Signature]

Nurse Name:

Chandana

Date & Time:

9/12/2024 2:30am



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 8/7/26

Assessment: Baby having Discomfort

Goals

- | | | | | | |
|---|---|--|---|--|--|
| ☒ Maintain Airway and Oxygenation | ☐ Relieve Pain & Discomfort | ☒ Maintain Fluid Balance | ☐ Improve Activity Tolerance | ☒ Maintain Good Nutritional Status | ☐ Maintain Skin Integrity |
| ☒ Maintain Personal Hygiene | ☒ Prevent Infection | ☐ Meet Elimination Needs | ☒ Ensure Safety | ☐ Early Ambulation Reduce Anxiety | ☒ Patient & Family Education |
| ☐ Identify Potential Complications | ☐ Any Others. Specify..... | | | | |

Time	Plan of Care	Time	Implementation	Evaluation
8am	→ Assess the baby general condition & monitor the vital sign.	8:30 am	→ Assessed the baby general condition & monitored the vital sign.	Baby condition is improved
10am	→ Maintain the I/O chart	10:30 am	→ Maintained the I/O chart	
11am	→ provide the comfortable position.	11:30 am	→ provided the comfortable position.	
12pm	→ Administer the medication as per doctor order	12:30 pm	→ Administered the medication as per doctor order	
1pm	→ Maintain IV fluids.	1:30 pm	→ Maintained the IV fluids	

Re-Assessment: Re-Assessment Bp monitoring 6-8 hourly

Special Notes:

Nurse Signature: V. Ravina

Nurse Name: V. Ravina (607729)

Date & Time: 8/7/26 3:00 pm



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 9/2/26

Assessment: Baby having null Activity

Goals

- | | | | | | |
|---|---|--|---|--|--|
| ☒ Maintain Airway and Oxygenation | ☐ Relieve Pain & Discomfort | ☒ Maintain Fluid Balance | ☐ Improve Activity Tolerance | ☒ Maintain Good Nutritional Status | ☐ Maintain Skin Integrity |
| ☒ Maintain Personal Hygiene | ☒ Prevent Infection | ☐ Meet Elimination Needs | ☒ Ensure Safety | ☐ Early Ambulation Reduce Anxiety | ☒ Patient & Family Education |
| ☐ Identify Potential Complications | | | | | |
| ☐ Any Others. Specify..... | | | | | |

Time	Plan of Care	Time	Implementation	Evaluation
2pm	Assess the general condition of the patient	2:30 pm	Assessed the general condition of the patient	Baby condition is good
3pm	monitor the vitals signs	3:30 pm	monitored the vitals signs	
	maintain I/O chart		maintained I/O chart	
4pm	Administer medication	4:30 pm	Administered medication	
5pm	as per as chart		as per as chart	
	maintain fluid Balance	5:30 pm	maintained fluid Balance	
6pm	Ensure the patient safety	7pm	Ensured the patient safety	

Re-Assessment: T2 - Assessment

Special Notes:

Nurse Signature: All

Nurse Name: Nikita

Date & Time: 9/7/26 @ 8pm

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NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 10/7/2026

Assessment: Baby is having dull activity

Goals

- | | | | | | |
|---|---|--|---|--|--|
| ☐ Maintain Airway and Oxygenation | ☐ Relieve Pain & Discomfort | ☐ Maintain Fluid Balance | ☐ Improve Activity Tolerance | ☒ Maintain Good Nutritional Status | ☐ Maintain Skin Integrity |
| ☒ Maintain Personal Hygiene | ☒ Prevent Infection | ☒ Meet Elimination Needs | ☒ Ensure Safety | ☐ Early Ambulation Reduce Anxiety | ☒ Patient & Family Education |
| ☐ Identify Potential Complications | ☐ Any Others. Specify..... | | | | |

Time	Plan of Care	Time	Implementation	Evaluation
8pm	⇒ Assess the general condition of the baby	8:10pm	⇒ Assessed general condition of the baby	The baby condition is Improving slowly
10pm	⇒ provide comfortable bed and position	10:10pm	⇒ provide comfortable bed and position	
12AM	⇒ monitor vital signs	12:10AM	⇒ monitor vital signs	
4am	⇒ Administer medication as per doctor order	4:10AM	⇒ administered medication as per doctor order	
6am	⇒ Educate personal hygiene	6:10AM	⇒ Educated personal hygiene	

Re-Assessment: Baby is having dull activity

Special Notes:

Nurse Signature: Rama

Nurse Name: Rama

Date & Time: 10/7/2026 8am

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NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

Goals

- | | | | | | |
|---|--|---|---|---|---|
| ☐ Maintain Airway and Oxygenation | ☐ Relieve Pain & Discomfort | ☐ Maintain Fluid Balance | ☐ Improve Activity Tolerance | ☐ Maintain Good Nutritional Status | ☐ Maintain Skin Integrity |
| ☐ Maintain Personal Hygiene | ☐ Prevent Infection | ☐ Meet Elimination Needs | ☐ Ensure Safety | ☐ Early Ambulation Reduce Anxiety | ☐ Patient & Family Education |
| ☐ Identify Potential Complications | ☐ Any Others. Specify..... | | | | |

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment:

Special Notes:

Nurse Signature: Nurse Name: Date & Time:



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Alisha Department: ward Date of Admission: 7/7/26

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known					
	<u>persistent diarrhea</u>		If Yes Specify:					
BACKGROUND	Area	Shift Time	<u>6P</u> <u>5pm</u>	<u>1st</u> <u>5pm to 8pm</u>	<u>1st</u> <u>8pm to 11pm</u>	<u>1st</u> <u>11pm to 2am</u>	<u>OT</u> <u>2am to 11:30</u>	<u>1st</u> <u>11:30 to 8pm</u>
	Medical Condition (Any special condition to be noted):		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
ASSESSMENT	Allergy:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:	Temp:	<u>97.8°F</u>	<u>98.4°F</u>	<u>98.4°F</u>	<u>98.1°F</u>	<u>98.6°F</u>	<u>98.0</u>
		Res:	<u>28bpm</u>	<u>28bpm</u>	<u>26bpm</u>	<u>28bpm</u>	<u>25bpm</u>	<u>26bpm</u>
		SpO ₂ :	<u>99%</u>	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>99%</u>
		Pulse:	<u>105bpm</u>	<u>110bpm</u>	<u>106bpm</u>	<u>117bpm</u>	<u>105bpm</u>	<u>106bpm</u>
		BP:	<u>124/95</u>	<u>110/60</u>	<u>102/69</u>	<u>102/62</u>	<u>105/61</u>	<u>106/70</u>
	Fall Risk Score:	<u>11</u>	<u>11</u>	<u>11</u>	<u>11</u>	<u>11</u>	<u>11</u>	
Pain Score:	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>1/10</u>	<u>0/10</u>		
Recommendations	Safety Needs:	<u>yes</u>	<u>yes</u>	<u>Side rails</u>	<u>yes</u>	<u>yes</u>	<u>yes</u>	
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Handed Over By Name :		<u>Pooja</u>	<u>Shanku</u>	<u>Priyanka</u>	<u>Rashmi</u>	<u>Shanku</u>	<u>Shanku</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>7/7/26</u>	<u>7/7/26</u>	<u>8/7</u>	<u>8/7</u>	<u>8/7/26</u>	<u>8/7</u>	
Time:		<u>5pm</u>	<u>8pm</u>	<u>8AM</u>	<u>11:30</u>	<u>9pm</u>	<u>18pm</u>	
Taken Over By Name :		<u>Shanku</u>	<u>Priyanka</u>	<u>Rashmi</u>	<u>Priyanka</u>	<u>Shanku</u>	<u>Shanku</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>7/7/26</u>	<u>7/7/26</u>	<u>8/7</u>	<u>8/7</u>	<u>8/7</u>	<u>8/7/26</u>	
Time:		<u>3pm</u>	<u>8pm</u>	<u>@ 8am</u>	<u>12:00</u>	<u>2pm</u>	<u>@ 8pm</u>	



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Alisha Department: Neonatology Date of Admission: 7/7/26

SITUATION	Diagnosis: <u>Persistent Diarrhoea</u>		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:				
BACKGROUND	Area	<u>1st floor</u> <u>8pm-8am</u>	<u>1st floor</u> <u>8am-2pm</u>	<u>1st floor</u> <u>2pm-8pm</u>	<u>1st floor</u> <u>8pm-8am</u>		
	Shift Time						
BACKGROUND	Medical Condition (Any special condition to be noted):	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>		
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No ☐ Yes ☐ No	
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No ☐ Yes ☐ No	
	Vital Signs:	Temp:	<u>98.5°F</u>	<u>98.2°F</u>	<u>98°F</u>	<u>98.0°F</u>	
		Res:	<u>26b/m</u>	<u>26b/m</u>	<u>23m</u>	<u>28b/m</u>	
		SpO ₂ :	<u>99%</u>	<u>100%</u>	<u>100%</u>	<u>100%</u>	
		Pulse:	<u>116b/m</u>	<u>117b/m</u>	<u>110b/m</u>	<u>106b/m</u>	
		BP:	<u>98/64</u>	<u>102/62</u>	<u>99/69</u>	<u>90/70</u>	
	Fall Risk Score:	<u>0/10</u>	<u>10</u>	<u>10</u>	<u>11</u>		
	Pain Score:	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>		
	Recommendations	Safety Needs:	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>	
Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No ☐ Yes ☐ No	
Others Specify:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>		
Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No ☐ Yes ☐ No	
Other Special Orders / Medications:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>		
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>		
Handed Over By Name :		<u>Chondane</u>	<u>Ravina</u>	<u>Nikish</u>	<u>Rama</u>		
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>		
Date:		<u>9/7/26</u>	<u>9/7/26</u>	<u>9/7</u>	<u>10/7/26</u>		
Time:		<u>28am</u>	<u>2pm</u>	<u>8pm</u>	<u>8pm</u>		
Taken Over By Name :		<u>Shanthi</u>	<u>Nikish</u>	<u>Rama</u>	<u>Rama</u>		
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>		
Date:		<u>9/7/26</u>	<u>9/7</u>	<u>9/7/26</u>	<u>10/7</u>		
Time:		<u>28am</u>	<u>2pm</u>	<u>8pm</u>	<u>8am</u>		



THE HUMPTY DUMPTY SCALE

7/7 8/7 9/7 10/7

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3	3	3	3	3	
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2	2	2	2	
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1	1	
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1	1	1	1	1	
	History of Falls or Infant - Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2	2	2	
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	1	1	1	
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1	1	
TOTAL			11	11	11	11	

Intervention :

-Fall Risk : Low Humpty Dumpty Score = 7-11,

High Risk Humpty Dumpty Score = 12 or above

Bed in low position	yes	yes	yes	yes
Call device within reach	yes	yes	yes	yes
Wheels Locked	yes	yes	yes	yes
Room free of clutter	yes	yes	yes	yes
Adequate Lighting	yes	yes	yes	yes
Wheel Chair Support	no	no	no	no
Other Intervention(s) Specify	no	no	no	no
Nurse's Name :	Pooja	Pragya	Chand	Rama
Signature :	[Signature]	[Signature]	[Signature]	[Signature]
Date :	7/7	8/7	9/7/26	9/7/26
Time :	2:30 pm	6:45 am	6 am	6 am

BAH-00466849 IP5-00176074
Master MOHAMMED AARIS JIBRAAN
17-11-2019 6 Y 7 M 20 D (M)
Dr. ALISHA BASSAR



BRADEN 'Q' SCALE

Rainbow
Children's
Hospital
It takes a lot to treat the little.

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

		Date :	7/7	8/7	9/7/26	10/7/26		
		Time :	2:30pm	6AM	6am	6AM		
Mobility	completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	4	4
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4	4
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot not always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4
Nutritional Usual food intake - pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4
TOTAL SCORE					28	28	28	28
Evaluator's Name					pooja	Prigya	Chand	Rama

Severe Risk : less than 9 | High Risk : 10-12 | Moderate Risk : 13-14 | Mild Risk : 15-18 | Not at Risk: 19-23

Docu. No. : RCHBH /FRM / CLINICAL / 119

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice
15-18	At Risk	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for “At Risk” Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	• Follow the same protocol as for “Moderate Risk” Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for “High Risk” Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

BAH-00468849
Master MOHAMMED AARIB JIBRAAN
17-11-2019 8 Y 7 M 20 D (M)
Dr. AJISHA BASBAR



PAIN ASSESSMENT FORM

Date	Time	Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
7/7/26	2:30 pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA NA	poorja
7/7	4:30 pm	1/10	Abdomen	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	PO. PCM	Pain, Shant
8/7	6 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Poorja
8/7	12:45 pm	1/10	SS	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☒ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Poorja
8/7	9 pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Self
9/7	6 am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Chandane
9/7	2 pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Rama
9/7	10 pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Rama
10/7	6 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Rama
			PM	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	

Re-assessment Frequency:

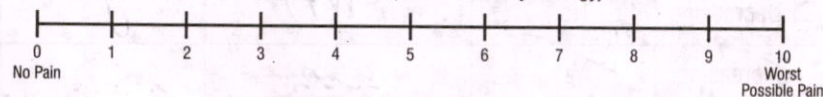
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, rigid, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams of sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

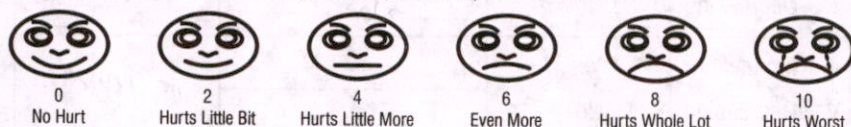
Numerical Pain Scale (Obstetric and Gynecology)



Neonatal Pain, Agitation and Sedation Scale (upto 1 Month)

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR, RR, BP, SaO₂	No variability with stimuli Hypventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years





CHECKLIST FOR THROMBOPHLEBITIS

9/7/25

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0			0							cannula changed
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1			+	1						cannula changed
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			-							
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3			-							
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4			-							
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5			-							
Signature of the Nurse						Rama							

NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personal ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

Signature :  Name : 

Signature of Ward In Charge :

Signature :  Name : 

BAH-00466849 IP5-00176074
Master MOHAMMED AARIB JIBRAAN
17-11-2019 6 Y 7 M 20 D (M)
Dr. ALISHA BABBAR



CHECKLIST FOR THROMBOPHLEBITIS

**Rainbow®
Children's
Hospital**
It takes a lot to treat the little.

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0		0	0				0	0	0	
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1		-	-	1	-	-	-	-	-	cannula Removal
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2		-	-				-	-	-	
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3		-	-				-	-	-	
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4		-	-				-	-	-	
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5		-	-				-	-	-	
Signature of the Nurse													

NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personnel ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

Signature : Sourav Name : Sourav

Signature of Ward In Charge :

Signature : N Name : Neeraj

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

BAH-00466849 IP5-00178074
Master MOHAMMED AARIB JIBRAAN
17-11-2019 6 Y 7 M 20 D (M)
Dr. ALISHA BASSAR

(Hindi)

Patient / Learner Literacy:

☒ Read ☒ Write ☐ Speak

Willingness to Learn: ☒ Yes ☐ No

Healthcare Literacy: ☒ Yes ☐ No

Identified Education Needs

- | | | | |
|----------------------------|--|--|---|
| 1. Diagnosis | 5. Medication / Therapy (safety, effects/ side effect, interactions) | 9. Nutrition / Diet | 13. Risk / Safety |
| 2. Treatment and Care Plan | 6. Discharge Medication | 10. Fall Risk Education | 14. Activity / Exercise |
| 3. Pain Management | 7. Infection Control Measures | 11. Safe use of Medical Equipment / Implantable Devices Safety | 15. Social & Rehabilitation Needs |
| 4. Informed Consent | 8. Diagnostic Test / Procedures | 12. Patient's / Family Rights | 16. Special Discharge / Follow-up Education / Coping Skills |
| | | | 17. Others |

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
7/7/20	2:40 pm	7	infection control measures	M	4	0	1	1	NA	poorja
7/7/20	3pm	9	Gastro diet (Inhered e rice based food) (Avoid egg, wheat, nuts, milk, ragi, oats, sugar) (PTN's Food)	M	1	0	1	1	-	monika

Part - III: CODES

Who was taught: PT: Patient F: Father M: Mother S: Spouse Sn: Son D: Daughter C: Caregiver O: Other (Specify)							
Learning Barriers: 1. No Learning Barriers 2. Physical Impairment 3. Emotional Barriers 4. Language Barrier 5. Educational Level 6. Desire / Motivate to Learn 7. Impaired Thought Process/Cognitive limitations 8. Responsibilities at Home 9. Cultural Differences 10. Financial Difficulties 11. Beliefs and Values 12. Impaired Vision/ or Hearing 13. Cultural/Religion Practice 14. Others (Specify)							
Teaching Tools Used: A: Audio D: Demonstration V: Video O: Oral P: Printed							
Mechanism/s to overcome barrier/s: 1. None 2. Obtain translator 3. Reassurance & Support 4. Teach Family / Others 5. Respect values & beliefs 6. Respect Cultural / Religion Preference 7. Other, Specify							
Understanding: 1. Verbalizes Understanding 2. Demonstrates Understanding 3. Needs Review							

MULTI-DISCIPLINARY PLAN OF CARE FORM

 BAH-00468849
 Master MOHAMMED AARIB JIBRAAN
 17-11-2019 6 Y 7 M 20 D (M)
 Dr. ALISHA SABBAR


Peristent diarrhoea.

	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
7/11/26 3pm	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Abdominal pain	U-sheduly	Iv f Antibiotic	prabhakar ☒ Nursing ☐ Others:
7/11/26 3pm	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Abdominal pain	U-stability	Iv fluids	Shavani ☒ Medical ☐ Others:
7/11/26 2pm	☐ Medical ☐ Nursing ☒ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Tafewell's & Peristent Diarrhoea	Crastor diet	RDA E:- 1450kcal/d P:- 25g/d	Moukesh ☐ Medical ☐ Nursing ☒ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op				☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op				☐ Medical ☐ Nursing ☐ Others:



CONSENT FORM FOR _____, REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE



Patient Name : Mohammed Aarib Jibraan Age : 6y 7m Gender : Male ☒ Female ☐

UHID NO: _____ Surgeon Name: Dr Alisha

Anaesthesiologist : Dr. Alisha N

Operative procedure planned : Upper GI endoscopy

PLEASE READ THIS BEFORE YOU CONSENT FOR ANAESTHESIA

General anaesthesia involves rendering a patient unconscious before an operation. This ensures the patient is not aware of events and does not feel pain during the operation. Drugs given through a vein and / or inhaled from an anaesthesia machine produce it. Regional anaesthesia involves using a local anaesthetic to numb a specific area of the body for surgery: Prolonged pain relief without numbness can be achieved by infusing weak solutions of local anesthetics and narcotic drugs to particular parts of the body after surgery or injury, using catheters.

Specific High Risk (s) : The doctors have explained to me the details of the high risk involved due to the following medical problems and I have sought necessary clarification on all my doubts.

- | | | | |
|---|---------------------------------------|---|--|
| ☐ Heart disease | ☐ Hypertension | ☐ Diabetes mellitus | ☐ Renal failure |
| ☐ Hepatic disorders | ☐ Shock | ☐ Multiple organ failure | ☐ Polytrauma / Renal Tubular Acidosis |
| ☐ Incapacitating Chronic Obstructive Pulmonary Disease | | | |
| ☐ Others : <u>laryngospasm.</u> | | | |

Comments : _____

- Doctor to document in medical record also if necessary (Cross-out if not applicable)

DECLARATION BY PATIENT / GUARDIAN / PROXY

I hereby authorize Rainbow Hospital & its authorized doctors to perform upon me / my patient Mohammed Aarib Jibraan the above mentioned operation / Diagnostic / Therapeutic procedures Upper GI Endoscopy

I authorize and give consent for anaesthesia (☐ Regional / ☐ General Anesthesia / ☒ Monitored Anesthesia Care as considered appropriate by the anaesthetic team.

I acknowledge that the anaesthetists have informed me about the anaesthetic procedure, risk, benefits and alternative treatments and answered my specific queries and concerns about this matter. I have read and understood the information provided in this form I acknowledge that I have discussed with the anaesthetists any significant risk and Complications specific to my individual circumstances, and I have considered them before Consenting for anesthesia.

I understand that there are some infrequent complications that can occur due to use of anaesthesia, these include pain or some injury at the site of injections, temporary breathing difficulties, asthmatic reactions, headaches.

I authorize the anaesthetic team to perform any additional procedures (for example, Central Venous Pressure line, arterial line, use of nerve blocks for pain relief, changing from regional to general anaesthesia etc), which are considered necessary by them during the course of surgery.

That I authorize and give consent to the team of doctors attending on me to administer blood products during the course of operative period and immediately thereafter in need arises.

I understand that the above mentioned consultant anesthesiologist or occasionally a colleague deputed by him / her will administer the Anaesthesia.

- Pregnant : ☐ Yes ☒ No

DECLARATION BY THE ANAESTHETISTS PROVIDING INFORMATION FOR THIS CONSENT

I declare that I have explained the nature of General Anaesthesia / Regional Anaesthesia / Monitored Anesthesia Care to be given and discussed the risks that particularly concern this patient.

I have given the patient an opportunity to ask questions and I have answered these.

Patient / Patient Attendant :

Signature : Amara
Name : Amara Tazeen
Relationship with Patient: Mother
Date & Time : 8/7/26, 11:30 AM

Witness :

Signature : Atif Goman
Name : Atif Goman
Date & Time : 8/7/26, 11:30 AM

Doctor (who is taking the consent) :

Signature : Sundhara
Name : Dr Sundhara
Date & Time : 8/7/26 11:30 AM

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

BAH-00466849 IP5-00176074
Master MOHAMMED AARIB JIBRAAN
17-11-2019 6 Y 7 M 20 D (M)
Dr. ALISHA BABBAR



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children's
hospital
takes a lot to treat the little.

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Name: Age: Sex: UHID.No :

Date: 7/7/2021 Time: 9:30 Proposed Operation: Upper GI endoscopy

Diagnosis: ? jejunitis

B.P / CRT: 100/62 H.R: 102 Weight: 19kg ASA Physical Status: ☒ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb: 13.1 Glucose: Protein: HIV: X-Ray:
PCV: 40.3 Urea: 23 Alb: HBS Ag: ECG:
WBC: 13780 Creat: 2.4 Total Bill: HCV: 2D Echo:
Plate: 492 Na: 139 Dir. Bill: Blood group: Stress/Angio:
PT: K: 4.6 LDH: T3: Other:
PTT: Ca++: Alk phos: T4:
INR: Mg++: Amylase: TSH:
CRP: 12
ESR: 34
Cl-: 99 SGOT/SGPT:
Allergies: No known allergy

Medical History: CVS: -

RESP: - 15-20 days loose stool → now constipated

CNS: - abdominal pain since 1 day

Renal: - memory → leprosy

Hepatic / GE: pain in abdomen, jejunitis Physical Activity: -

Others: -

Past Anaesthetic History: crumison 1 mbc 1 day &

Physical Exam:

Airway: MP 1 2 3 4 Mouth Opening: Mentohyoid Distance: Neck: Teeth:

Lungs: AETBT

Heart: S52

CNS: -

Pregnant: ☐ Yes ☐ No ☒ NA Venous Access Site: antecubital

Anaesthetic Plan: ☒ MAC ☐ REGIONAL ☐ GA-ETT ☐ LMA

Peri-Operative Plan Explained to the Patient: ☒ Yes ☐ No

CURRENT MEDICATIONS	DOSAGE
IVW CEFTRIAXONE	
IVW MERONIDAZOL	
IVW ESOMEPRANOL	
Syp Azithromycin	
Syp TRAMADOL	

Pre-Operative Instructions:

- DVT Prophylaxis:
 - Water / ORS 2 Hours
 - Others 6 Hours
- NIL ORAL: ☒ Standard ☐ High Risk
- Informed Consent: ☒ Discussed with Patient
- Post Operative Pain Management: ☐ Discussed with Patient
- Other Instructions: consent pending

Stop clear liquid 2 hrs before procedure

Signature: Aditi Name: Dr Aditi



ANAESTHESIA CHART

Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☒ No		Fasting Status: <u>>6hrs</u>	
Physical Status: ☒ Patient Identified		☒ Consent Present	
		☒ Chart Reviewed	
H.R: <u>108b/min</u>	B.P / CRT: <u>100/80</u>	SpO ₂ : <u>96.2%</u>	R.R: <u>16/min</u>
Pre-OP Diagnosis:		Operation: <u>upper GI Endoscopy</u>	
Surgeon: <u>Dr. Alisha Babbar</u>		Date: <u>8/2/26</u>	
Anaesthesiologist: <u>Dr. S. O. Do D.R.</u>		Technician: <u>Man</u>	

TIME	12:00	12:30pm	12:45pm
N ₂ O /AIR /O ₂ LPM	<u>02</u>	<u>4</u>	<u>4</u>
HALO /SO /SEVO			
Drugs:	<u>0.5mg Midazolam 0.5mg</u> <u>0.5mg Fentanyl - 30mcg</u> <u>0.5mg Propofol - 3mcg + 2mcg + 2mcg + 3mcg + 2mcg + 2mcg + 2mcg</u>		
FiO ₂ / SaO ₂	<u>98.1</u>	<u>96.1</u>	<u>97.1</u>
ETCO ₂	<u>16</u>	<u>30</u>	<u>30</u>
ECG	<u>NSR</u>	<u>NSR</u>	<u>NSR</u>
Temperature	<u>36.5</u>	<u>36.5</u>	<u>36.5</u>
Urine Output	<u>0</u>	<u>0</u>	<u>0</u>

Fluids	Blood
B.P	240
V Systolic	220
A Diastolic	200
X Mean	180
• Heart Rate	160
Tourniquet on Time	140
Tourniquet off Time	120
Throat Pack In	100
Throat Pack Out	80
	60
	40
	20
	10
	0

LAB Values
ABG
GRBS
Others

☒ Equipment Checked and Functional ☒ BP <u>4.0</u> ☒ Cuff Site: <u>4.0</u> ☐ Art Site: ☐ EKG Lead ☐ Temp Site ☐ FIO ₂ Monitor ☐ Agent Monitor ☒ Pulse Oximeter ☒ Capnograph ☐ Ventilator ☐ Nerve Stimulator Position: <u>Supine</u> ☐ Pressure Points Checked	Temp: ☐ HME ☐ Fluid Warmer ☐ Cling Film ☐ OH Warmer ☐ Hugger's ☐ Cotton Wool ☐ Other Times: Anaes Start: <u>12:00pm</u> OP Start: OP End: <u>12:40pm</u> Leave OR: Anaesthesia: ☒ GA ☐ Monitored Anaesthesia Care ☐ Regional Line (Size & Location) ☐ CVP: ☐ ART: ☒ IV: <u>22G @ 4.0</u> ☐ IV: ☐ IV:	Induction ☒ IV ☐ Inhal ☒ Pre O ₂ ☐ RSI ☐ Others ☐ Mask ☐ SGA ☐ Airway ☐ Oral ☐ Nasal ETT# at cm ☐ Oral ☐ Nasal ☐ Cuff ☐ Tracheostomy ☐ Topical ☐ Drug: ☐ Awake ☐ Direct Vision ☐ Video Laryngoscopy ☐ Stylette / Bougie ☐ Fiberoptic Blade# Attempts: Difficulty Why? ☐ Bilal = BS ☐ Semi-Closed Circle ☐ Closed Circle ☒ Other
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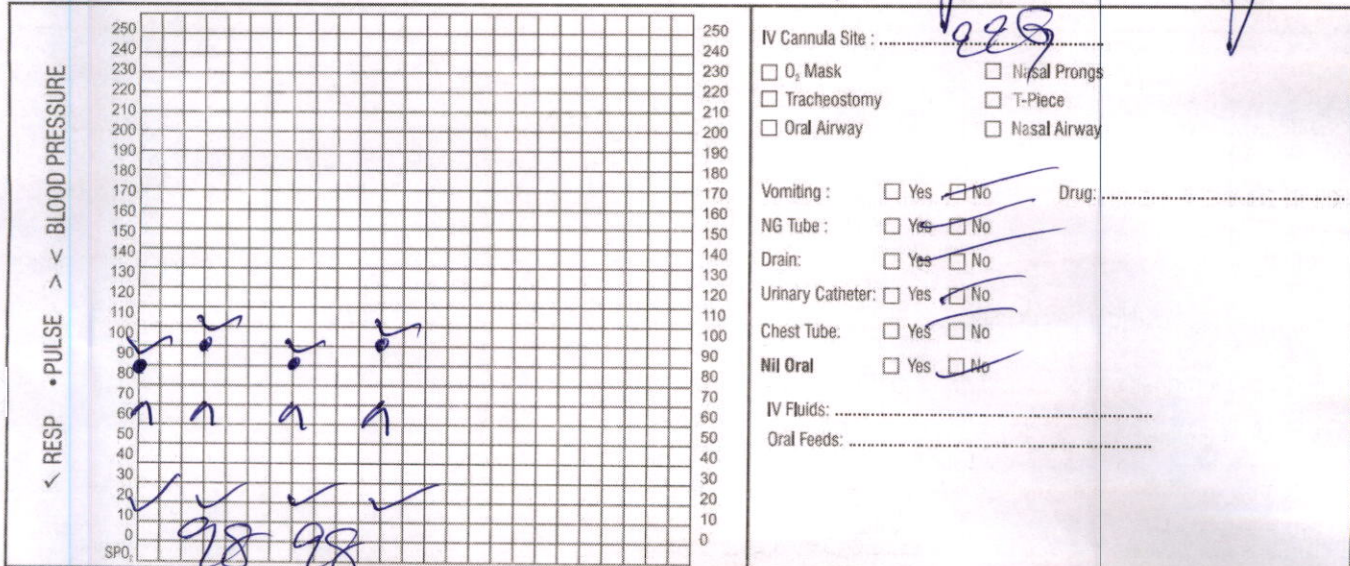
Regional: Extremity Specify: ☐ Spinal ☐ Epidural ☐ Caudal Others: Position: Site: Needle Size: Depth: Parasthesia ☐ Yes ☐ No Catheter at skin cm Drug Name & Conc: Bolus: Infusion: Block Level: Comments: Transportation to ☒ PACU ☐ ICU ☐ Other Relaxant Reversed ☒ Yes ☐ No ☐ NA Name of the Doctor: <u>Dr. Akande</u> Signature of the Doctor: <u>[Signature]</u>
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POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Dr. K. S. Surys

Time Received : 12:45 pm Time Discharged : 2 pm



POST ANAESTHESIA SCORE (Modified Aldrete Score)			IN	MINUTES			OUT	SCORING INTERPRETATION
				30	60	90		
Able to move 4 extremities voluntary or on command	= 2	ACTIVITY	1	1	1	2	A Minimum Total Score of 8 is Required for Discharge Exceptions to this, are to be explained in the space below by the Discharging Physician:	
Able to move 2 extremities voluntary or on command	= 1							
Able to move 0 extremities voluntary or on command	= 0							
Able to deep breathe & cough freely	= 2	RESPIRATION	2	2	2	2		
Dyspnea or limited breathing	= 1							
Apneic	= 0							
BP $\pm$ 20 of Pre Anaesthetic level	= 2	CIRCULATION	2	2	2	2		
BP $\pm$ 20-50 of Pre Anaesthetic level	= 1							
BP $\pm$ 50 of Pre Anaesthetic level	= 0							
Fully awake	= 2	CONSCIOUSNESS	1	1	2	2		
Arousable on calling	= 1							
Not responding	= 0							
Pink	= 2	COLOR	2	2	2	2		
Pale, dusky, blotchy, jaundiced, other	= 1							
Cyanotic	= 0							
TOTAL			8	8	9	10		

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
8/11/20	12:45 pm	1/10	—	Dr. K. S. Surys

Pain Tool Used: ☐ N PASS ☒ FLACC ☐ Wong Baker ☐ NPS

Anaesthesiologist Name : Dr. K. S. Surys

Anaesthesiologist Signature: [Signature]

Date & Time: 8/11/20 @ 2 pm

PACU Nurse Name : [Signature]

PACU Nurse Signature: [Signature]

Date & Time: 8/11/20 @ 2 pm

Reassessment Frequency:

- Every eight hours for all hospitalized patients.
- For post surgical patient, patient with chronic pain, patient with severe pain
 - Every 2 hours for first 24 hours
 - After 24 hours every 4 hours
 - Prior to pain relieving intervention
 - With in 30-60 minutes after pain relief intervention

Transferred to Unit by (PACU): 12:10

Date & Time: 8/11/20 @ 2 pm

Patient Sticker

Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

Date: Time: Procedure done by

CSE /Spinal /Epidural Position : Space : Technique (LOR/LOS)

Depth: Catheter at Skin: Attempts :

Parasthesia : Yes/No if yes details :

Solution Composition :

Any other issues :

a)

b)

Time	Infusion Rate (ml/hr)	Bolus (ml)	Level Left Right		Maternal		FHR	Comments
					BP	Pulse		

Delivery Details : Time : APGAR: SVD / Instrumental / LSCS (if LSCS Details)

Catheter Removed by and Tip Inspected :

Patient Satisfaction :

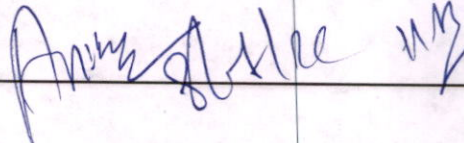
Discharge /Shifting ordered by

Doctor Signature:

Doctor Name:

Date and Time :

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00466349 IP5-00176074 Master MOHAMMED AARIB JIBRAAN 17-11-2019 6 Y 7 M 21 D (M) Dr. ALISHA BABBAR 		Date & Time of Admission 7/7/26 @ 11:00pm	Date & Time of Transfer Order 7/7/26 @ 1:00pm
		Transfer Ordered by Dr. Suroya	Reason for Transfer Post-op
From Unit OT	To Unit 121D	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 22	Number of Imaging Films nil	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐			
Name & Signature of Person who is Transferring 		Name of Person Ordered Transfer Dr. Suroya	
Patient & Clinical Records Received by : 			
Date & Time of Patient Received :			

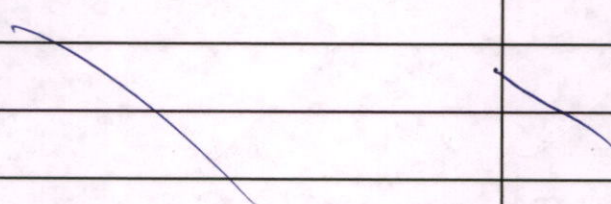
If the transfer order time & Completion time is more than 30 minutes, please tick the reason mentioned below :

☐ Unavailable Bed

☐ Nurse not Available

☐ Available Bed not ready

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00466849 IP5-00176074 Master MOHAMMED AARIB JIBRAAN 17-11-2019 6 Y 7 M 21 D (M) Dr. ALISHA BABBAR 		Date & Time of Admission 7/7/26	Date & Time of Transfer Order 7/7/26 @ 11:30 am
		Transfer Ordered by Dr. Alisha Babbar	Reason for Transfer upper GI endoscopy
From Unit 121-D	To Unit OT	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 25	Number of Imaging Films No	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring V. Ravina		Name of Person Ordered Transfer Dr. Alisha Babbar	
Patient & Clinical Records Received by : Teer			
Date & Time of Patient Received : 8/7/26 @ 11:40 am			

If the transfer order time & Completion time is more than 30 minutes, please tick the reason mentioned below :

☐ Unavailable Bed

☐ Nurse not Available

☐ Available Bed not ready

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00465849 IP5-00176074 Master MOHAMMED AARIB JIBRAAN 17-11-2019 6 Y 7 M 20 D (M) Dr. ALISHA BABBAR 		Date & Time of Admission 7/7/26 @ 1:40pm	Date & Time of Transfer Order 7/7/26 @ 3:03pm
		Transfer Ordered by Dr. prathiba	Reason for Transfer Admission
From Unit ER	To Unit ICU	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 21	Number of Imaging Films No	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ op file If yes, what? Amaret	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	1/2 DNS	1	
2.	Intoxifex	1	
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring NR. pooja		Name of Person Ordered Transfer Dr. prathiba	
Patient & Clinical Records Received by : Shanthi			
Date & Time of Patient Received : 07/07/26 3:20pm			

If the transfer order time & Completion time is more than 30 minutes, please tick the reason mentioned below :

☐ Unavailable Bed

☐ Nurse not Available

☐ Available Bed not ready

BAH-00465849
Master MOHAMMED AARIB JIBRAAN
17-11-2019 6 Y 7 M 20 D (M)
Dr. ALISHA BABBAR

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Children's
Hospital
It takes a lot to treat the little.

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Your Right to a Safe Delivery

DISCHARGE PLANNING FORM

Nationality: Indian

NOTES: * To be completed by a NURSE within (24) hours of admission.

1. Anticipated Date of Discharge: ay per doctor ordo

2. Destination Post Discharge: ☒ Home

Family Members Notified (Person Contacted)

☐ Transfer

Hospital Facility Notified (Person Contacted)

3. Discharge Status: ☐ Self Care ☐ Family Home Care ☐ Home Professional Assistance

☐ Needs Assistance In:

Remarks

☐ Medication ☒ Yes ☐ No

☐ Bathing ☐ Yes ☒ No

☐ Eating ☐ Yes ☒ No

☐ Walking ☐ Yes ☒ No

☐ Dressing ☐ Yes ☒ No

☐ Toileting ☐ Yes ☒ No

explain to mother

4. Nutritional Plan:

☐ Dietary Instruction Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

5. Discharge Planning Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

6. Patient/Family Educational Plan:

☐ Educational Topic/s: hand hygiene

☐ Patient's Educational Topic/s discussed with the:

☐ Patient ☐ Family Member

☐ Others:

Nurse Signature: shubh

Nurse Name: shubh

Date and Time: 02/07/26 @ 3pm



1210
NUTRITIONAL HEALTH ASSESSMENT - BOYS

Date: 7/7/26 Time: 3pm

Weight: 19kgs Centile: 10th

Height: 116cm Centile: 25th

Inference: Underweight child

RDA: — Calories: 1450kcal/d Protein: 25g/d

Diet Recommendations: Gastron diet [include rice based food]

Re-Assessment: Avoid Egg, wheat, Ragi, oats, citrus fruits, sugar, nuts, milk, etc

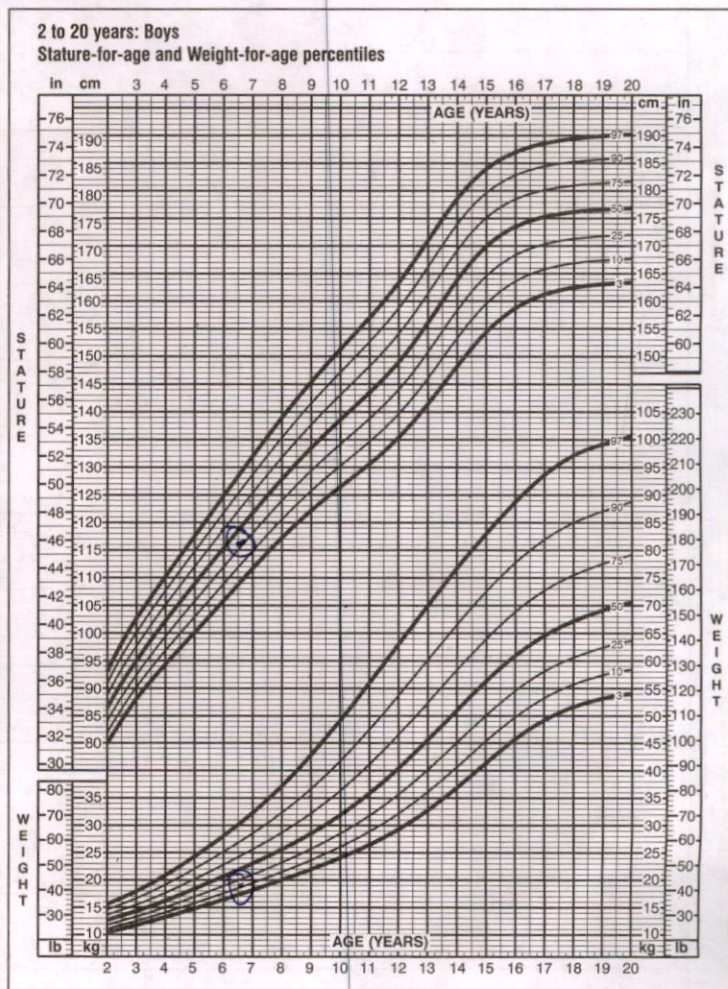
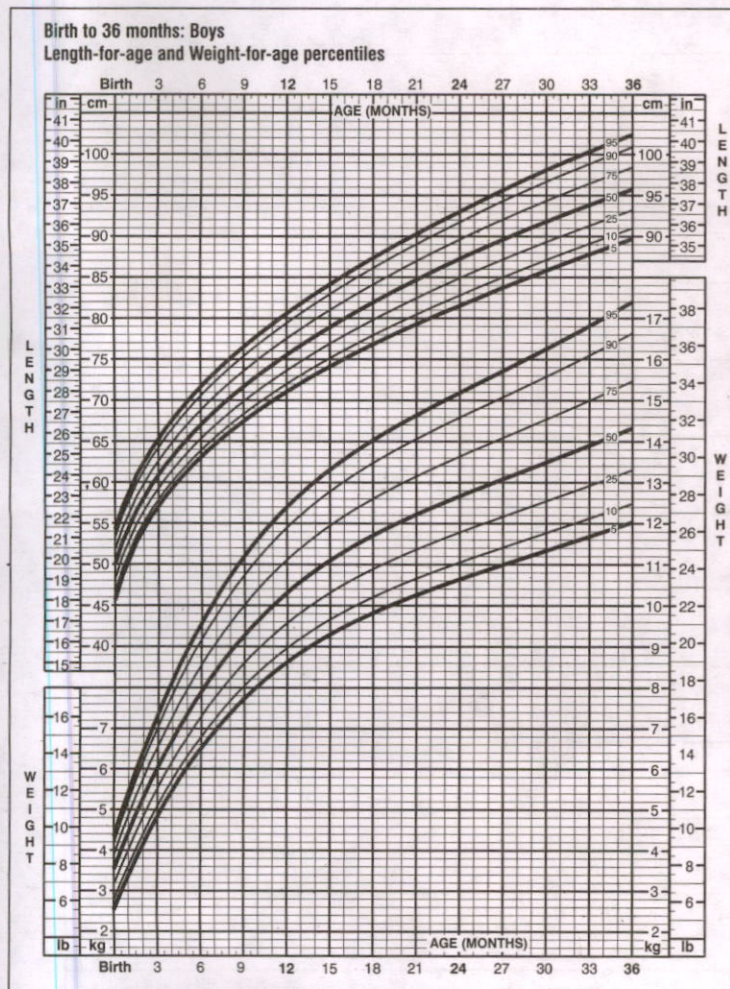
Food Allergies: No Veg/Non-veg: non-veg

Diagnosis: Infantile I persistent diarrhea

Nutritional Intervention - ☒ Oral ☐ Enteral ☐ Parenteral

Patient's Signature: Amare

GROWTH CHART (BOYS)



Dietician's Name: Mounica

Dietician's Signature: Mounica

Daily Notes:

9/2/06
8am

Child is stable. Intake is fair

continue on soft diet as advised

no other

10/7/06
8:30am

Child is stable Intake is optimal

Continue on soft diet as advised.

no other